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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JENNA ELIZABETH REYES** **aka ELIZABETH MAHER** **10476 Paymaster Road** **Valley Center, CA 92082** **Registered Nurse Licence No. 639566** **Public Health Nurse Certificate No. 68936** Respondent.	Case No. 2010-96 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN, (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 7, 2004, the Board of Registered Nursing issued Registered Nurse License 639566 to Jenna Reyes (Respondent). Said license was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2010. On June 2, 2005, the Board of Registered Nursing issued Public Health Nurse Certificate No. 68936 to Respondent. Said certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2010.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

". . . ."

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, (CCR) section 1442, states:

"As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. CCR section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. CCR section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

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COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

11. On October 15, 2007, at approximately 0825 hours, 85-year-old patient B.L.N was brought to PMC's Emergency Room (ER) by paramedics. The patient was experiencing shortness of breath and rapid atrial fibrillation (fast irregular hear rate). On admission, B.L.N. was diagnosed as having renal insufficiency (kidneys working poorly) and possible sepsis (severe infection) from aspiration pneumonia or urinary tract infection.

12. Between 0825 and 1715 hours on October 15, 2007, during the ER say, B.L.N. was treated through an I.V. with Cardizem 5 mgs and 10 mgs., two doses of Dixogin 0.25 mgs, both for the fast heart rate, antibiotics for the infection, and fluids. This was documented in the patient's medical record.

13. Respondent assumed the care of B.L.N. at approximately 1715 hours. At approximately 1815 hours, Respondent contacted Dr. F regarding the patient's low blood pressure (68/38) and heart rate (160 beats per minute). Respondent documented a telephone order by Dr. F. at 1935 hours for "Dixogin 1.25 IV X 1 now V/O". Respondent had doubts about the Dixogin dosage ordered and documented that she repeated the order back twice to the physician. Respondent then obtained three vials of Digoxin .5 mg from the Pyxis (medication dispensing machine) using the override function and administered Digoxin 1.25 mg IV to the patient.

14. The use of the Pyxis override function is limited only to first doses and only in emergent situations when the resulting delay would harm the patient. Medications with a rapid onset of effect may be considered for override. Digoxin had been administered to the patient two times previously on the same day. Respondent was aware of the previous doses. Digoxin is not an emergency response medication and does not have a rapid onset. The standard Dixogin dose is 0.5 mg-1mg IV in divided doses, and is adjusted lower for renal insufficiency. A total of 0.5 mgs.

had already been given in to the patient in the ER. The maximum initial recommended one time dose is 0.5 mgs, and subsequent doses should be no higher than 0.25 mg. In the case of this patient, with her age and renal insufficiency, the dose probably should not have been higher than 0.125 mgs: 10 times less than the actual dose given.

15. PMC's medication administration protocol includes that all physician's orders must be reviewed by a pharmacist. This gives the pharmacist an opportunity to review them for drug interactions, allergies, and appropriate amounts and dosages. The pharmacist then registers the prescription on the patient's electronic administration record by medication name, dose, and route. The nurse then clicks on the prescription and accesses the medication from Pyxis.

16. Respondent withdrew Digoxin from Pyxis via the override function which circumvented the review of the physician's order by the pharmacist. Had Respondent followed hospital procedures, the pharmacist would have recognized the error and taken steps to clarify Respondent's withdrawal.

17. Respondent knew or should have known that the dose of Digoxin prescribed by the physician, which Respondent understood to be 1.25 mg., was more than 10 times the dosage that the patient should have been prescribed (0.125 mg), and Respondent knew from the MAR that the patient had already received two doses of the drug at the time she received the telephone prescription order from the physician. Respondent withdrew 1.5 mg. of the medication from Pyxis, overriding the controls in order to do so, and then administered 1.25 mg of the medication Digoxin. Additionally, Respondent failed to include the minimum required elements of a valid medication order in that the order Respondent documented did not include "mg".

18. It is the policy of PMC to review all patient deaths using a Root Cause Analysis (RCA). The review of B.L.N.'s death concluded that Respondent's administration error was one of several contributing factors in the patient's death.

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CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence)

19. Respondent is subject to discipline under Code section 2761(a)(1) on the grounds of incompetence and gross negligence, as defined by CCR sections 1442 and 1443 in that on or about October 15, 2007, while working at Palomar Medical Center (PMC), Respondent failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent nurse as described in CCR section 1443.5, and/or failed to provide nursing care as required, or exercise ordinary precaution which she knew or should have known would jeopardize the patient's health or life, as follows:

A. Respondent failed to adhere to accepted hospital protocol and failed to meet the standards for medication administration safety as outlined in PMC's procedures, when she administered patient B.L.N. an excessive amount of Digoxin;

B. Respondent knew or should have known that the dosage of Digoxin should not have been 1.25 mg for the patient, but she administered the dosage anyway;

C. Respondent over-rode the Pyxis machine to remove the 1.25 mg dosage of Digoxin, which should not have been done when previous doses of the drug had been administered to the patient;

D. Respondent did not verify the prescription for 1.25 Digoxin with the hospital pharmacist, as hospital protocol required, but administered the dose despite her own concerns that the dosage was incorrect.

E. Respondent did not record the dosage of Digoxin that she administered to the patient by including the measure, "mg."

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 639566, issued to Jenna Elizabeth Reyes, aka Jenna Elizabeth Maher;

2. Revoking or suspending Public Health Nurse Certificate No. 68936 issued to Jenna Elizabeth Reyes, aka Jenna Elizabeth Maher;

3. Ordering Jenna Reyes, aka Jenna Elizabeth Maher, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: 8/19/09

LOUISE R. BAILEY, M.Ed., R.N.
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2009803841